Filing at a Glance

Company:	American United Life Insurance Company
Product Name:	EOI- MIB
State:	Arkansas
TOI:	H11G Group Health - Disability Income
Sub-TOI:	H11G.004 Other
Filing Type:	Form
Date Submitted:	09/10/2012
SERFF Tr Num:	AULD-128678838
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	EOI- MIB/HEALTH
Implementation Date Requested:	On Approval
Author(s):	Bridget McGill, Angie Neville, Danita Ragland-Hatton
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/12/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name:
Project Number: G-23223-EOI
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 09/12/2012
State Status Changed: 09/12/2012
Created By: Danita Ragland-Hatton
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 08/17/2012
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Danita Ragland-Hatton

Filing Description:
September 10, 2012

Jay Bradford. Commissioner
Department of Insurance
State of Arkansas
1200 West Third Street
Little Rock, AR 72201-1904

Re: American United Life Insurance Company - NAIC #60895
Statement of Insurability, G-23223-EOI
Statement of Insurability - to be used with Group Life and Disability Income Insurance and Individual Life Insurance forms

Dear Commissioner Bradford:

Attached for information is the Statement of Insurability form. An additional MIB authorization has been added as required by MIB.

The Statement of Insurability form has not been used or issued. The form was originally filed as follows:
Filing SERFF # Approval Date
Statement of Insurability -Life filing
Statement of Insurability –Disability filing AULD-127685512
AULD-127685909 10-10-2011
10-12-2011

The change required by MIB is to include language in our MIB authorization that elicits an applicant's express written consent to report information to MIB. The following sentence has been added to the Authorization and Acknowledgement section: I/we authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. So you can easily determine what was added, the sentence has been underlined in each form.

This filing is for the sole purpose of revising the MIB authorization language. We certify that this is the only language change made to the Statement of Insurability.

State: *Arkansas* ***Filing Company:*** *American United Life Insurance Company*
TOI/Sub-TOI: *H11G Group Health - Disability Income/H11G.004 Other*
Product Name: *EOI- MIB*
Project Name/Number: */G-23223-EOI*

Please acknowledge approval of this updated form via SERFF.

You may call me at 1-877-285-7660 (ext 1809) or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

Company and Contact

Filing Contact Information

Bridget McGill, Sr. Contract Analyst
One American Square
Indianapolis, IN 46206

Bridget.McGill@oneamerica.com
317-285-1809 [Phone]

Filing Company Information

American United Life Insurance Company
One American Square
P.O. Box 7127
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 60895
Group Code: 619
Group Name:
FEIN Number: 35-0145825

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

Company	Amount	Date Processed	Transaction #
American United Life Insurance Company	$50.00	09/10/2012	62540811

SERFF Tracking #:	*AULD-128678838*	***State Tracking #:***		***Company Tracking #:***	*EOI- MIB/HEALTH*

State:	*Arkansas*	***Filing Company:***	*American United Life Insurance Company*
TOI/Sub-TOI:	*H11G Group Health - Disability Income/H11G.004 Other*		
Product Name:	*EOI- MIB*		
Project Name/Number:	*/G-23223-EOI*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/12/2012	09/12/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/10/2012	09/10/2012

Response Letters

Responded By	Created On	Date Submitted
Danita Ragland-Hatton	09/11/2012	09/11/2012

SERFF Tracking #:	*AULD-128678838*	***State Tracking #:***		***Company Tracking #:***	*EOI- MIB/HEALTH*

State:	*Arkansas*	***Filing Company:***	*American United Life Insurance Company*
TOI/Sub-TOI:	*H11G Group Health - Disability Income/H11G.004 Other*		
Product Name:	*EOI- MIB*		
Project Name/Number:	*/G-23223-EOI*		

Disposition

Disposition Date: 09/12/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Supporting Document	Response letter dated 9-11-12	Approved-Closed	Yes
Form	Statement of Insurability	Approved-Closed	Yes

State: Arkansas **Filing Company:** American United Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: EOI- MIB
Project Name/Number: /G-23223-EOI

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/10/2012
Submitted Date	09/10/2012
Respond By Date	

Dear Bridget McGill,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Statement of Insurability, G-23223-EOI (Form)
Comments:

If this form is used as a stand alone form, it must contain a Fraud Statement.

Thank you for your understanding and cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking #:	AULD-128678838	**State Tracking #:**		**Company Tracking #:**	EOI- MIB/HEALTH

State:	Arkansas	**Filing Company:**	American United Life Insurance Company
TOI/Sub-TOI:	H11G Group Health - Disability Income/H11G.004 Other		
Product Name:	EOI- MIB		
Project Name/Number:	/G-23223-EOI		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/11/2012
Submitted Date	09/11/2012

Dear Rosalind Minor,

Introduction:

Dear Ms. Minor,

Response 1

Comments:

Please see the attached response letter.

Related Objection 1

Applies To:

- Statement of Insurability, G-23223-EOI (Form)

Comments:

If this form is used as a stand alone form, it must contain a Fraud Statement.

Thank you for your understanding and cooperation.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Response letter dated 9-11-12
Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your assistance with our filing.

Bridget McGill
Senior Contract Analyst
Sincerely,

SERFF Tracking #:	*AULD-128678838*	***State Tracking #:***		***Company Tracking #:***	*EOI- MIB/HEALTH*

State:	*Arkansas*	***Filing Company:***	*American United Life Insurance Company*
TOI/Sub-TOI:	*H11G Group Health - Disability Income/H11G.004 Other*		
Product Name:	*EOI- MIB*		
Project Name/Number:	*/G-23223-EOI*		

Danita Ragland-Hatton

SERFF Tracking #:	*AULD-128678838*	***State Tracking #:***		***Company Tracking #:***	*EOI- MIB/HEALTH*

State:	*Arkansas*	***Filing Company:***	*American United Life Insurance Company*
TOI/Sub-TOI:	*H11G Group Health - Disability Income/H11G.004 Other*		
Product Name:	*EOI- MIB*		
Project Name/Number:	*/G-23223-EOI*		

Form Schedule

Lead Form Number: G-23223-EOI

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/12/2012	G-23223-EOI	AEF	Statement of Insurability	Initial:	50.200	G-23223-EOI 8-6-12.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318

OneAmerica®

Section A: Proposed Insured *(complete Statement of Insurability)*

Proposed Insured Name: ______________________

Driver's License Number ______________ State where Issued ______________

Height ______ ft. ______ in. Weight ______ lbs. ☐ Gained ☐ Lost ______ lbs. In Past Year

Spouse and/or Child(ren) must complete Statement of Insurability if required for Group Coverage.
Whole Life Insurance Coverage not available for Spouse/Children.

Spouse/Partner Name *(Last, First, Middle)*
Gender ☐ M ☐ F Birth Date ______________ Birth Place ______________
Driver's License # ______________ State where Issued ______________
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)*
Relationship to You ______________ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______________ Birth Place ______________
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)*
Relationship to You ______________ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______________ Birth Place ______________
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)*
Relationship to You ______________ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______________ Birth Place ______________
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)*
Relationship to You ______________ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______________ Birth Place ______________
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: ***(Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Cancer, malignancy, or tumor of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, thyroid, or other glandular disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. High blood pressure or hypertension?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m. Skin or lymph node disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n. Eye, ear, nose, mouth, or throat disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section B: Health Questions *(continued)*

2. Within the past 5 years, has any applicant for insurance: ***(Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Taken in the past, or is currently taking, any prescription medicine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Received or been instructed to seek treatment for use or abuse of: ☐ Alcohol ☐ Drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Currently, is any Applicant: ***(Provide details to any "yes" response in Section 4.)***

a. Pregnant? Expected delivery date: _____ *(List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name _____

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

If more than one applicant has used nicotine, provide full details in Section 4.

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	*Question No.*	*Details of injury, illness, or disorder*	*Date*	*Name of Physician, Hospital, or Other Provider*

Authorization and Acknowledgement

I/we authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me (and my spouse and/or my dependents, if they are to be insured): facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. I/we authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. I/we understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I/we can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my/our knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I/we certify that all notices contained herein were read and understood prior to my/our completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured / Employee *Mo. / Day / Year*

Printed Name of Proposed Insured / Employee

Signature of Spouse / Partner *Mo. / Day / Year*

Printed Name of Spouse / Partner

Signature of Dependent Child Age 18+ *Mo. / Day / Year*

Printed Name of Dependent Child Age 18+

SERFF Tracking #:	*AULD-128678838*	***State Tracking #:***	***Company Tracking #:*** *EOI- MIB/HEALTH*

State:	*Arkansas*	***Filing Company:***	*American United Life Insurance Company*
TOI/Sub-TOI:	*H11G Group Health - Disability Income/H11G.004 Other*		
Product Name:	*EOI- MIB*		
Project Name/Number:	*/G-23223-EOI*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	09/12/2012
Comments:			
Attachment(s):			
Cert of Compliance AR.pdf READCERT FOR HEALTH.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	09/12/2012
Bypass Reason:	N/A		
Comments:			

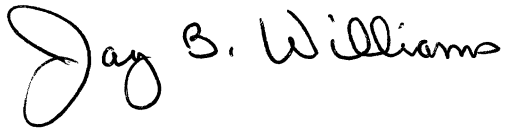
		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variables	Approved-Closed	09/12/2012
Comments:			
Attachment(s):			
Statement of Variables - G-23223-EOI.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Response letter dated 9-11-12	Approved-Closed	09/12/2012
Comments:			
Attachment(s):			
'12 AR Objection response 9-11-2012.pdf			

CERTIFICATE OF COMPLIANCE

State of Arkansas

I, Jay B. Williams, Vice President Chief Compliance Officer, of the AMERICAN UNITED LIFE INSURANCE COMPANY®, hereby certify that the enclosed Forms comply with all Insurance Statutes, Regulations, and Departmental requirements of the State of Arkansas.



Jay B. Williams
Vice President Chief Compliance Officer

Date: September 7, 2012

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS	READABILITY SCORE
G-23223-EOI	50.2

Jay B. Williams

September 7, 2012

Jay B. Williams
Vice President and Director of Compliance

STATEMENT OF VARIABLES
G-23223-EOI

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223-EOI	Statement of Insurability	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
"	"	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
"	Section A	Spouse and children	Bracketed so the spouse and children questions may be deleted if evidence of insurability information for spouse and children are not applicable. Bracketed for ease in updating as need arises whenever there is a change in product(s) offered to the spouse and children– the change could be in a product name or it could be a new product that has been filed and approved by the state
"	Section B	Spouse and Children columns	Bracketed so the spouse and children area may be deleted if evidence of insurability for spouse and children are not applicable.
"	Authorization and Acknowledgement	"I/we", "my/our" and "(and my spouse and/or my dependents, if they are to be insured)"	Bracketed so the references to spouse and children may be deleted if evidence of insurability for spouse and children are not applicable.
"	Signatures	Signatures for Spouse and children	Bracketed so the spouse and children signature items may be deleted if evidence of insurability for spouse and children are not applicable.

ONEAMERICA®

September 11, 2012

Rosalind Minor
Department of Insurance
State of Arkansas
1200 West Third Street
Little Rock, AR 72201-1904

Re: American United Life Insurance Company - NAIC #60895
Statement of Insurability, G-23223-EOI
Statement of Insurability - to be used with Group Life and Disability Income Insurance

Dear Rosalind Minor:

Thank you for the quick response to our filing. In your objection letter you have asked if the Statement of Insurability form is a stand-alone form.
No, the Statement of Insurability form is not a stand-alone form. It will be used with the following forms: Request for Coverage when Evidence of Insurability is Required, G-23985, and Fraud Notices, G-22373. These forms were filed under SERFF # AULD-128586450.

We trust that you will now find our submission in good order.

Please acknowledge approval of this updated form via SERFF. However, if you need any other information, just let me know.

You may call me at 1-877-285-7660 (ext 1809) or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

American United Life Insurance Company®
a ONEAMERICA® *company*
One American Square
P.O. Box 368
Indianapolis, IN 46206-0368
(317) 285-1877